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ABSTRACT

The locus of mental health care for individuals with severe and persistent mental illness continues to shift from inpatient units to outpatient and community services. Among community-based approaches, assertive community treatment (ACT) teams have demonstrated clinical and cost effectiveness in state and federal public systems. However, public sector psychologists are underrepresented on the ACT teams. This paper identifies some contributing factors and potential solutions for the current situation from the perspective of five Veterans Administration psychologists. Participants provide rationale for inclusion of psychologists on ACT teams, clarify their role with respect to clients and treatment teams, and review disincentives and benefits of psychologist participation in multi-disciplinary community services. Symposium topics include: (1) identification of reasons why psychologists are needed on ACT teams; (2) an outline of some contributions psychologists can make to the care of people with serious mental illness; (3) a description of psychologists' approaches to case management services for clients in the community; (4) highlights of the psychologist's clinical role with respect to the ACT team; and (5) discussion of some of the barriers and rewards for psychologist participation. (Contains 19 references.) (JDM)

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Is There a Place for Psychology in Assertive Community Treatment?

APA Division 18 Symposium
Chair:
Michael Neale, Ph.D.

Presenters:
Dolly Sadow, Ph.D.
"The ACT Psychologist as Scientist-Practitioner-Teacher"

Mark Ward, Ph.D.
"The Seriously Mentally Ill: Psychologists' Unique Contributions"

Michelle Mang, Ph.D.
"ACT Psychologist as Case Manager: Assessment, Consultation, and Therapy"

Mark Morooney, R.N., Ph.D.
"ACT Psychologist: Serving the Client and the Team"

John Simpson, Ph.D.
"ACT Psychologists: Accomplishments and Inhibiting Factors"

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Michael Neale, Ph.D. VA Northeast Program Evaluation Center (West Haven, CT)

"Assertive Community Treatment: What's a Psychologist to Do?"

The locus of mental health care for individuals with severe and persistent mental illness continues to shift from inpatient units to outpatient and community services. Among community-based approaches, assertive community treatment (ACT) teams have demonstrated clinical and cost effectiveness in state and federal public systems. The U.S. Department of Veterans Affairs now funds 44 ACT teams that provide services for veterans with serious mental illness under the program name of Intensive Psychiatric Community Care (IPCC). Like most ACT programs, IPCC teams target individuals with high needs and resource use histories for case management services characterized by low client to staff ratios, frequent contact, individualized assessment, continuity, and a practical, problem-solving orientation. ACT and IPCC teams are typically composed of a multidisciplinary staff that shares treatment planning and caseloads, and generalizes work while respecting professional skills and training.

Public sector psychologists are relatively under-represented on ACT and IPCC teams, although psychologists possess unique training and experience that can substantially enhance the quality of treatment and rehabilitation services, team performance, and research. This symposium will identify some contributing factors and potential solutions for the current situation, from the perspectives of five VA psychologists with over 25 years of combined experience as case managers, team leaders, and administrators with Intensive Psychiatric Community Care (IPCC) teams. Participants will: (1) clarify their roles and relationships with respect to the team, clients, and system administrators; (2) provide a rationale for inclusion of psychologists on ACT teams; and (3) review disincentives and benefits of psychologist participation in multi-disciplinary community services.

Dr. Sadow, IPCC program director (Bedford, Massachusetts), will identify reasons why psychologists are needed on ACT teams. Dr. Ward, Outpatient Clinic and IPCC program director (Portland, Oregon), will outline some of the unique contributions that psychologists can make to the care of people with serious mental illness. Dr. Mang, IPCC case manager (Seattle, Washington), will describe a psychologist's approach to case management services for clients in the community. Dr. Morooney, IPCC case manager (Perry Point, Maryland) will highlight the psychologist's clinical role with respect to the team. Dr. Simpson, Coordinator for Community Services (Brockton, Massachusetts) will discuss some of the barriers and rewards for psychologist participation and the need for psychologists to expand their point of view. Presentations will be brief to allow discussion and audience questions.

Dolly Sadow, Ph.D.

"The ACT Psychologist as Scientist-Practitioner-Teacher"

I would like to focus on reasons why psychologists are needed in IPCC, reasons that have much to do with the training that psychologists, particularly clinical psychologists, receive. More so than in other professions, the model for training of clinical psychologists is that of a scientist-practitioner-teacher. All three roles are explicitly stated and encouraged throughout our training. The "Scientist" role emphasizes the importance of basing clinical and programmatic decisions on objective evidence and research literature. Systematic data collection and review, for clinical assessment and treatment planning, program evaluation, and outcome measurement, is a cornerstone of good clinical work and clinical management. In these times of cost containment, such skills are essential not only to ensure excellence in clinical practice, but more pragmatically, to ensure program survival.

The role of teacher is also essential. The psychologist not only has an extensive and sophisticated "bag of tricks" for helping people heal, but also knows how to pass these skills on to others. Continuing pressures to economize on service costs by utilizing paraprofessionals, volunteers, and peer counselors, underscore the need for promoting quality services through training and supervision. These are roles for which psychologists are well prepared and their significance cannot be overemphasized.

Finally, as researchers and teachers, psychologists are able to advance the field and nourish academic affiliations. This capacity enriches clinical work by creating a culture of new ideas and learning for staff, and provides additional person power in the form of students for teams where resources have been plundered or overextended.

We must continue to generalize and adapt our knowledge of assessment, healing principles, boundaries, evaluation, and research, so that it is transportable to all locations and situations. Since community treatment for people who have serious mental illness is challenging, revolutionary, skilled, creative work that respects individual needs and feelings, obviously we need psychologists to do it!

Mark Ward, Ph.D.

"The Seriously Mentally Ill: Psychologists' Unique Contributions"

Psychologists' clinical and scientific training prepares them for unique and valued roles in programs caring for the seriously and persistently mentally ill. These roles are not often readily apparent, are not in the skill base of most other mental health disciplines, and are frequently overlooked when case management teams are being formed.

With training in scientific methods and statistical techniques, psychologists are ideally prepared to help ACT teams deal with the age of accountability by identifying valid and reliable outcome measures, designing systems for demonstrating a program's or a clinical procedure's effectiveness and collecting cost/benefit data. Pressures from multiple constituencies to demonstrate clinical and programmatic efficiency have heightened the necessity of collecting and presenting relevant outcome and cost data. In this climate, psychologists' facility with data and statistical methods can make the difference between a program that thrives and one that dies.

In addition to data-related skills, clinical psychologists are typically the most highly trained mental health professionals in the area of therapeutic modalities and group dynamics, with substantial implications for clinical and team management. In the clinical realm, providing care to clients with serious mental illness requires comfort with a range of treatment modalities. This is particularly true for clients with both a major mental illness and a substance abuse problem or personality disorder, who typically require treatment beyond medication management and traditional case management approaches. With grounding in theory and treatment of personality disorders, and familiarity with cognitive, behavioral, dynamic, systems, group and family treatment models, psychologists are often best prepared to engage clients with multiple problems in a cooperative, therapeutic relationship, and to provide crucial supervision and consultation to other team members struggling with such clients. Psychologists' knowledge of group dynamics and their ability to help other team members to work more efficiently with one another and with the health care system often make them a good choice to lead community treatment teams.

Michelle Mang, Ph.D.

"ACT Psychologist as Case Manager: Assessment, Consultation, and Therapy"

Psychologists have much to offer and much to gain as members of multidisciplinary ACT teams. As case managers, psychologists conduct clinical assessments, provide consultation to family members and/or other agency personnel, and design, implement, and evaluate psychological interventions that include supportive psychotherapy. As psychologists, we are well versed in techniques for in-depth, competent clinical assessment - the cornerstone of treatment planning. IPCC client assessments are enhanced by the psychologist's ability to utilize an array of tests and measures, and synthesize findings into a coherent formulation. Psychologists' consultation training is a great asset in facilitating communication with clients and significant others, and helping clients to navigate bureaucratic channels for critical housing, medical care, and financial support.

Psychologists have the therapeutic training to help a team select the therapeutic or rehabilitation activity that best meets a client's needs, including: suggestion, reinforcement, advice, reality testing, cognitive restructuring, limit setting, social skills training, and environmental interventions, many of which fall under the rubric of "supportive psychotherapy". Often dismissed as less than "real therapy" or assistance that any layperson could provide, supportive therapy with difficult clients in community settings is remarkably complex and challenging for even the most competent psychologist. The case manager therapist becomes a significant figure for the client, often serving as an auxiliary ego and role model during the performance of traditional case management duties, with the ultimate goal of helping clients establish or maintain their highest level of functioning.

ACT psychologists do not trade traditional expressive therapy in office settings to simply broker services or deliver medications the community. Rather, ACT psychologists are active providers whose assessments incorporate a full picture of client functioning, and whose services address the breadth of human life. The diversity of circumstances faced by people with serious mental illness and the intensity of ACT services offer many opportunities for psychologists to utilize their extensive skills and training.

Mark Morooney, R.N., Ph.D.

"ACT Psychologist: Serving the Client and the Team"

Members of an ACT team have multiple responsibilities. As case managers for people with severe mental illnesses, resulting impairments, and limited social or financial resources, their role requires familiarity with the signs, symptoms, and sequelae of mental disorders and with psychopharmacological treatments and side effects; but also with available housing, training, employment, and benefit resources. The transformation of mental health care from institutional to community services has expanded the responsibility and timetable for such "brokering" tasks, from one-time discharge planning to more continuous and integral involvement in a client's community life.

ACT case managers also function in a second capacity, as clinicians, using their training, skills, and life experience to help team and client define problems and needs, effect interventions for change, and assess their impact. Clinical psychology training offers good preparation for ACT, with extensive exposure, in diverse settings, to: personality theory and style; psychopathology; desensitization and behavioral therapy; cognitive restructuring techniques; relaxation, stress management, and coping skills; clinical assessment and interviewing techniques; individual, group, family, and organization systems and interventions; data collection, analysis, and interpretation. Throughout training, individual and group supervision during clinical internships and field placements bridges academic understanding with real world application of psychological principles and skills.

Occasionally, the intensity and complexity of ACT work may compromise the objectivity and clinical viability of a clinician or team, leading them to become reactive rather than proactive in their approach, and potentially undermining the structure for assessment and service delivery. In such cases, an ACT team psychologist may be called upon to provide supervision or "therapy" to the team member or to the team as a whole. The primary goal of this supervision is to assist the individual or team in maintaining objectivity in treatment and a proper focus on long-term goals. In this capacity, the psychologist blends individual and systemic interventions to play a significant role in the team's operation.

John Simpson, Ph.D.

"ACT Psychologists: Accomplishments and Inhibiting Factors"

Psychologists have played a significant role in the development, dissemination, and evaluation and research of ACT teams. Mary Ann Test, Ph.D. was a pioneering member of the original PACT model almost 30 years ago. Other psychologists have contributed to ACT research literature and model development, including Gary Bond Ph.D. in Indiana, Maxine Harris Ph.D. in the District of Columbia, Fred Frese Ph.D. in Ohio, Carol Mowbray Ph.D. in Michigan, an others. Relative to most clinical treatments, ACT and IPCC teams have shown remarkable leadership, attending to the details of clinical work and outcomes, and developing new methods for assessing program effectiveness. At almost every turn, psychologists have played a significant role. Yet, an examination of ACT teams reveals direct participation of psychologists to be dismally low. Why is this the case?

In the absence of empirical evidence, one is left to review some potential inhibiting factors: cost, interest, training, and choice. Cost: Higher salaries for psychologists may limit career opportunities to work directly in the area of psychosocial rehabilitation. Interest: Psychologists choosing clinical practice may lean toward work with people who have less severe disorders and for whom psychotherapy is the preferred mode of treatment. Training: Psychologists may choose to fill academic or clinical positions because they are more desirable or because that is how they were trained. Traditional training and internship programs do not support the use and development of psychological expertise in community-based settings, particularly in a psychiatric rehabilitation role. Choice: That psychologists might choose better paying jobs in traditional settings with less impaired clients is not surprising, though in part such a choice may reflect a pervasive and enduring cultural stigma regarding serious mental illness.

If psychology is to play a significant role in the rehabilitation and recovery of people with serious mental illness, then psychologists must continue to adapt their skills to new settings and service delivery systems.

What is Intensive Psychiatric Community Care (IPCC)?

VA Intensive Psychiatric Community Care (IPCC) teams provide community-based psychiatric and rehabilitation services to veterans with serious mental illness who are among the most frequent and long-term users of VA inpatient mental health resources. IPCC services are characterized by high staff to client ratios, shared caseloads, assertive outreach, frequent contact in community settings, a practical problem-solving approach, and high continuity of care. Interdisciplinary teams assume primary care responsibility and provide individualized care to help veterans: 1) reduce inpatient mental health service use and cost; 2) improve community adjustment and quality of life; and 3) enhance satisfaction with services. All IPCC veterans and staff participate in standardized national monitoring of program resources, client characteristics, service delivery, and outcomes in collaboration with the Northeast Program Evaluation Center (NEPEC). Evaluation and monitoring data have demonstrated the clinical and cost effectiveness of IPCC. Currently, 44 teams provide IPCC to over 2300 veterans nationwide.

Where are the existing IPCC Teams?

VISN 1	CT:	West Haven
	MA:	Bedford
		Brockton
	ME:	Togus
VISN 2	NY:	Albany
		Buffalo
		Canandaigua
		Syracuse
VISN 3	NJ:	East Orange
	NY:	Bronx
		Brooklyn
		Montrose
VISN 4	MD:	Perry Point (Baltimore)
	PA:	Coatesville
		Pittsburgh
VISN 6	NC:	Salisbury
VISN 7	AL:	Tuskegee (Montgomery)
	GA:	Atlanta
		Augusta
VISN 8	FL:	Gainesville
		Miami
VISN 9	TN:	Mountain Home
VISN 10	OH:	Chillicothe
		Cincinnati
		Cleveland
		Columbus
		Dayton
VISN 11	MI:	Ann Arbor
		Battle Creek
		Detroit (Allen Park)
VISN 12	IL:	Chicago (West Side)
		North Chicago
	WI:	Madison
VISN 13	MN:	Minneapolis
VISN 17	TX:	Dallas
		Waco (Temple)
VISN 19	CO:	Denver
VISN 20	ID:	Boise
	OR:	Portland
	WA:	American Lake (Seattle)
		Seattle
		Spokane
VISN 21	CA:	San Francisco
VISN 22	CA:	West Los Angeles

("VISN"=Veterans Integrated Service Network)

What are the minimum standards for an effective IPCC team?

Successful implementation of IPCC requires the following explicit administrative commitments, warranted by past experience and the relative resource intensity of IPCC services:

➤ Target veterans with **serious mental illnesses** and **impaired community functioning** (typically psychotic disorders, with or without accompanying substance abuse) who are **high utilizers of VA inpatient, residential, or crisis mental health services** (for whom traditional services have not resulted in stable community adjustment);

➤ Provide a dedicated staff of **five or more clinicians** with at least one nurse as well as psychiatric and office support. Some teams have operated with as few as three clinical staff, but small teams have been generally less effective and less enduring.

➤ Promote **team cooperation and morale** to enhance efficiency and continuity (crucial to team success);

➤ Identify a **team leader** whose duties include liaison with VA and community representatives, supervision of IPCC staff, and delivery of clinical services in the community;

➤ Support **frequent client contact** and **delivery of clinical services in the community**, including in vivo assessment, medication delivery, skills training, and rehabilitation services.

➤ Assure **off-hours team access** for guidance of inpatient and emergency clinical staff;

➤ Provide **ancillary resources** for safe and efficient community services, including:

- fixed, economical **team space**, at or near the medical center/clinic;
- dedicated **vehicles** for daily community visits by each clinician;
- dedicated **communication technology** (beepers, cell phones) to assure staff and client safety;
- electronic **office technology** (computers, copier, answering machine, fax machine) for organizing, charting, and monitoring clinical work;

➤ Establish **integrated links** between the IPCC team and other mental health/rehabilitation services (inpatient, outpatient, and community) to enhance service coordination;

➤ Maintain a **clear line of authority**, with the team leader represented in the mental health service or product line; and

➤ Assure **quality and accountability through monitoring** of program effectiveness and cost.

For additional information about IPCC, please contact: Robert Rosenheck MD or Michael Neale PhD, Northeast Program Evaluation Center (NEPEC)/182, VA Connecticut Healthcare System 950 Campbell Avenue, West Haven, CT 06516 (Phone: 203-937-3850; fax: 203-937-3433).

What is the history and scientific foundation of IPCC?

Intensive Psychiatric Community Care (IPCC) programs represent the adaptation, within VA, of **assertive community treatment (ACT)**, a model developed in the 1970's by Arnold Marx, Leonard Stein, and Mary Ann Test in Madison, Wisconsin (1-6). ACT is one of the most heavily researched psychiatric services for people with serious mental illness, recently recommended as a state of the art intervention by the Schizophrenia Patient Outcomes Reseach Team (PORT) study (7). The intent of ACT developers was to make the comprehensive services and support of an inpatient unit available to outpatients in the community, integrated within a single team. ACT helps people to reduce psychiatric inpatient hospital use and improve community adjustment, quality of life, and satisfaction with services (8-11). Implementation data further demonstrate that the success of a given ACT team is influenced by team fidelity to the model, staff cohesiveness, and host agency support for outpatient treatment (12-15). In 1998, the National Alliance for the Mentally Ill (NAMI) adopted the Madison ACT model as a central element of its national anti-stigma campaign.

Initially funded as a regional mental health demonstration program in 1987, nine original IPCC teams were compared via experimental design with standard VA aftercare services. Two-year findings revealed that IPCC veterans had significantly fewer hospital days and lower costs overall than veterans receiving standard VA treatment. Clinically, IPCC veterans scored significantly lower in psychiatric symptoms, and higher in functioning and satisfaction with services (16-17). Five-year outcomes showed sustained reductions in hospital use and improvements in psychiatric symptoms, functioning, and personal well-being for IPCC clients (18). Compared to a randomly assigned control group, 454 IPCC veterans averaged 158 fewer hospital days over five years. After accounting for program costs, the nine IPCC programs were responsible for VA cost reductions estimated at $12.8 million, or $2.6 million per year. The program was most successful at facilities that adhered to the model and showed performance improvements in other areas as well (15).

With the demonstration's success, 30 new IPCC teams were funded in 1994-95 as part of a national VA initiative that used successful teams as mentors for developing programs. System-wide monitoring data (FY 1997-98) indicate that: 1) IPCC programs serve veterans with severe, long-standing disabilities (77% psychotic diagnosis; 58% hospitalized for more than two years; mean of 135 hospital days in year preceding entry; 47% funds managed by representative payee); 2) IPCC staff provide frequent, continuous services in the community; 3) IPCC veterans show substantial reductions in hospital use (mean 87 days per veteran during the first twelve months of treatment) with commensurate reductions in inpatient costs ($74.4 million for 1659 veterans treated for twelve months); and 4) IPCC veterans show significant improvements in symptoms, functioning, quality of life, and satisfaction after six months in the program (18, 19).

IPCC offers **a tested and effective model for community-based treatment and rehabilitation of veterans with serious mental illness who are high users of VA psychiatric inpatient resources**. It is consistent with principles underlying VA's recent reorganization that emphasize novel outpatient delivery systems, enhanced accessibility, customer satisfaction, and cost savings. On the basis of IPCC's demonstrated effectiveness, the Mental Health Strategic Healthcare Group (MHSHG) and the Under Secretary's Special Committee for Severely Chronically Mentally Ill Veterans (SMI Committee) have encouraged NEPEC to assist VA facilities and networks with IPCC team development by providing training, technical assistance, and monitoring.

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IS THERE A PLACE FOR PSYCHOLOGY IN ASSERTIVE COMMUNITY TREATMENT?

VA Intensive Psychiatric Community Care (IPCC) Psychologists

ACT: What's a Psychologist to do?

Michael Neale, Ph.D.
Northeast Program Evaluation Center
West Haven, Connecticut

ACT / IPCC

- People w severe & persistent mental illness/ seriously impaired community functioning
- Multi-disciplinary professional team
- Shared low caseloads (8-15 clients per clinical FTE)
- Assertive outreach
- Community service delivery

ACT / IPCC

- Multiple contacts per day or week
- Crisis intervention
- 24-hour access to team
- Continuity of care
- Individualized treatment planning
- In vivo assessment, rehabilitation, skills training

What We Know About ACT/IPCC

- Helps reduce hospital use: high users*
- Reduces reported symptoms
- Enhances quality of life and satisfaction
- Slightly improves client functioning
- Added effects of : model fidelity, full resources, implementation support, system shift from inpatient to outpatient care

What We Don't Know About ACT/IPCC

- Benefits for low hospital users?
- Improvement of specific living skills?
- Duration of service delivery?
- Impact of involuntary participation?
- Characteristics of best teams/clinicians?
- Added effects: community anti-stigma training? consumer/family participation?

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Why Isn't Everyone Doing ACT?

- Resource reallocation politics
- Insufficient training resources/systems
- Down-sizing vs. Resource intensity
- Staff anxiety
- Community anxiety
- Case management stereotypes

What's a Psychologist to do? CLINICAL

- Community assessment measures/strategies
- Community supports, stigma reduction
- Peer support & self-help strategies
- Rehabilitation techniques and manuals
- Health behavior change (diet, exercise)
- Bibliotherapy, Telemental health
- Jail diversion, Voluntary treatment

What's a Psychologist to do? RESEARCH

- Treatment and rehabilitation strategies
- Attitude and behavior change
- Stress/coping by consumers and providers
- Team development
- Burnout prevention

What's a Psychologist to do? ACADEMIC

- Definition of terms (severe, persistent, serious mental illness)
- Bias, stigma
- Voluntary vs. Involuntary treatment
- Client-family-community education
- Indigenous supports
- TRAINING!

What's a Psychologist to do? ADVOCACY

- Populations, networks: consumers, family members, providers
- Settings: housing, jail/prison, employment, internet
- Systems change: health services, criminal justice, government, accreditation
- Diffusion of innovation: self-help, ACT

What's a Psychologist to do?

- There are roles for psychologists in community-based treatment services.
- Step outside.
- Connect with clients, family members, community members; agencies, advocates, employers, educators, students, media

Why Psychologists are Needed in ACT

Dolly Sadow PhD
IPCC
Bedford, Massachusetts

Scientist-Practitioner-Teacher Model

- Scientist:
  Objective Evidence
  Systematic Data Collection and Review

- Teacher:
  Training Paraprofessionals and Others
  Creating a Culture of New Ideas

We must Generalize and Adapt

Community Treatment Needs Us

The Seriously Mentally Ill:
Psychologists' Unique Contributions

Mark Ward, Ph.D.
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ACT Psychologist as Case Manager:
Assessment, Consultation, Therapy

Michelle Mang, Ph.D.
IPCC
Seattle, Washington

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ACT Psychologist as Case Manager

- Assessment
- Consultation
- Therapy

ACT Teams and Clinical Supervision

Mark Morooney RN PhD
IPCC
Perry Point, Maryland

Transference and Counter-Transference

ACT Risk Factors

- Frequent contact - up to daily
- Intense contact - 24-hour availability
- Lack of preparation -

Impact on ACT Provider: Destructive Cycle

- Conflict regarding interventions
- Freelance 'cowboy' provider functioning
- Burnout: lack of support, therapeutic isolation
- Limited understanding of consumer
- Lack of interdisciplinary treatment

Impact on Consumer

- Decrease of participation of all disciplines of team
- Limited motivation to move toward independent functioning
- Increase in hospital use

Implementation

- Clinical supervisor experience in community-based care
- Clear separation of clinical and administrative supervision
- Clinical supervision within program structure:
  - Increase effectiveness
  - Prevent staff defensiveness

ACT Psychologists: Accomplishments and Inhibiting Factors

John Simpson PhD
Community Support Services
Brockton, Massachusetts

Overview

- Historically, psychologists have had a formative role in ACT programming
- Psychologists have only a minimal presence on ACT teams
- Barriers: Interest, Training, Cost, Choice

Interest

- Early self-selection into other fields for those with a primary community orientation
- Treatment of SMI clients: "not real psychotherapy"
- Emphasis on quick improvement and more tractable problems

Training

- Professional role/office visit models
- Lack of ACT exposure during training and internship
- Lack of knowledge of schizophrenia
- Concerns about boundary issues and safety

Cost

- No national consensus that psychologists are key ACT team members
- Under-funding of ACT positions
- Need for realistic cost-benefit analyses

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Choice

- Traditional vs. Non-traditional treatment settings
- Fewer opportunities for professional advancement
- Difficulty and stigma traditionally associated with SMI clients
- Inadequate emphasis on rehabilitation and recovery of SMI clients